Cominarty (Pfizer) Vaccine Child 5-11yo Consent

Consent Checklist	YES	NO
Has your child recently been sick with a cough, sore throat, fever or other symptoms?	☐	☐
Has your child had Covid-19 before?	☐	☐
Has your child had a Covid-19 vaccination before?	☐	☐
Has your child had anaphylaxis to another vaccine or medication?	☐	☐
Does your child have a weakened immune system (immunocompromised)?	☐	☐
Does your child have a bleeding disorder, other blood disorder or take medication to thin their blood?	☐	☐
Has your child ever had any problems with their heart?	☐	☐
Are you a parent/guardian/substitute decision maker who has the authority to provide consent for vaccination on behalf of this child?	☐	☐

Child's information

Name:	
Medicare number:	
Date of birth:	
Address:	
Gender:	

Parent's / Guardian's information

Parent/Guardian Name	
Contact Ph. Number	
Email Address	

Consent to receive COVID-19 vaccine

I confirm that:

☐ I have received & understood information provided to me on COVID-19 vaccination

☐ None of the conditions above apply to this child, or I have discussed these and/or any other special circumstances with my regular health care provider and/or vaccination provider

☐ I am the Child's parent, guardian or substitute decision maker

☐ I have the authority to provide consent for this child to receive a course of Pfizer COVID-19 vaccination (two doses of the same vaccine)

Parent/guardian/substitute decision maker's name	
Parent/guardian/substitute decision maker's signature	
Date	